

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105926	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2024
NAME OF PROVIDER OR SUPPLIER Westminster Suncoast		STREET ADDRESS, CITY, STATE, ZIP CODE 1095 Pinellas Point Dr S Saint Petersburg, FL 33705	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>37999</p> <p>Based on observation, interview, and record review, the facility failed to protect the rights of one (#6) of one resident related to the physical abuse from a staff member.</p> <p>Findings included:</p> <p>On 9/23/24 at 10:15 a.m., Resident #6 was observed sitting in a specialized wheelchair in her room. The resident reported mistreatment considering how she was treated and informed writer you're probably the worst one. The resident would not explain the statement related to mistreatment stating, it's over and done with hopefully. The resident reported being blind.</p> <p>Review of Resident #6's Admission Record revealed the resident had diagnoses not limited to unspecified cerebral infarction, unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, recurrent moderate major depressive disorder, and adjustment disorder with other symptoms.</p> <p>Review of Resident #6's progress notes revealed the following:</p> <ul style="list-style-type: none"> - Late Entry behavior note, dated 9/16/24 at 1:51 p.m. and effective 9/14/24 at 1:49 p.m., Resident sliding out of chair, staff members assisted back up into chair. Resident grabbed staff member by shirt and almost pulled her down. No signs/symptoms (s/s) of distress at this time. Will continue to monitor. - Behavior note, 9/14/24 at 10:14 p.m., Resisting care for transfer to bed and changing clothes and brief. Explained need to have brief changed. Cursing at staff and spitting and resisting care but finally stops resisting and care is completed. Tolerates well and is no longer speaking to staff. <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Incident Report statement from Staff A, Certified Nursing Assistant (CNA), dated 9/16/24 at 2:03 p.m., showed on 9/14/24 at approximately 8:00 p.m. the staff member was attending to Resident #6 who had been refusing care, exhibiting combative behaviors, and despite multiple follow-ups the resident remained uncooperative. The report showed at 10:00 p.m. (40 hours prior to the report) the resident had calmed somewhat and Staff B, Registered Nurse (RN) offered to assist with changing the resident's shirt. The report showed during the process, the resident spat at Staff B who in response, while standing over the resident spat back at the resident, the exchange occurred again when the resident spat at the nurse who repeated the action. The resident became no longer combative, the aide did not require any further assistance, and the nurse was excused from the room to de-escalate the situation.</p> <p>A telephone interview was conducted with Staff A on 9/24/24 at 12:29 p.m. Staff A reported she needed help with Resident #6 as the resident was a mechanical lift and was in the process of getting changed. Staff A reported witnessing the resident spit at Staff B and then witnessed Staff B spit at the resident might have been 2-3 times. Staff A stated after the incident everyone was calm, the resident allowed to be changed. Staff A said (the resident) was probably shocked too. Staff A reported witnessing Staff B hold the resident's wrists down and thought the resident was trying to hit earlier in the night but not at that time. Staff A reported to Staff D, Nursing Supervisor, that Staff B had spit at the resident, and the supervisor told Staff A to write a statement for the administrator. Staff A stated the statement was written on Monday (2 days after the event).</p> <p>A telephone interview was conducted on 9/24/24 at 2:17 p.m. with Staff D, Licensed Practical Nurse (LPN). The staff member confirmed working on the 11 p.m. - 7 a.m. shift, having the most seniority on shift so guessed that made her the Charge Nurse. Staff D reported walking up on the CNA, who had witnessed the incident on 9/14/24, speaking with someone else (unidentified) about the nurse spitting on the resident. Staff D reported advising the CNA if something had happened it would have to be reported. Staff D reported not saying anything to anyone else (regarding the incident) because she was not the supervisor on duty when it happened.</p> <p>Review on 9/24/24 at 1:32 p.m. of the facility's transcription from Staff B conducted via telephone, showed the Staff A had requested assistance from Staff B with putting Resident #6 into bed. Staff B reported assisting Staff A at approximately 10-10:30 p.m. with evening care for Resident #6. It was reported the resident was resistive to care, hitting, clawing and spit at Staff B. The statement showed the staff were able to put on a nightgown while the resident sat in the wheelchair and as Staff B was holding [the resident's hands] so CNA could put on gown. Staff B reported the resident did spit at her and I may have spit back during my aggressive speaking. The staff member continued to report making spitting noises and I was upset I just wanted to get her changed. The statement showed Staff B continued to state [resident] was an angry bitter person. The statement showed when the Regional Director of Health Care Services attempted to address how to handle a resident with cognitive impairment Staff B raised voice, asking What do you want me to do?Am I just supposed to leave her like that? During a previous interview the NHA reported the statement was conducted with Staff B over the phone, was written verbatim and attended by the Regional Director, Director of Nursing, and NHA.</p> <p>Review of the staff sign-in sheets for Saturday September 14th and Sunday September 15th, 2024 showed Staff B, Registered Nurse (RN) was assigned to Resident #6's hall.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of September Medication Administration Record (MAR) for Resident #6 showed Staff B had administered medications and documented the resident's refusals on 9/14 and 9/15/24. On 9/14 and 9/15/24 during the evening shift, Staff B had documented the resident had not exhibited any behaviors related to the use of an antidepressant which included irritable.</p> <p>Review of Resident #6's Treatment Administration Record showed Staff B and applied both barrier cream to the resident's buttocks and peri-area and applied skin prep barrier to bilateral heels during the evening shift on both 9/14 and 9/15/24.</p> <p>During an interview on 9/24/24 at 12:14 p.m., Staff C, Certified Nursing Assistant (CNA) reported Resident #6 did get abusive and staff just walked away. When the resident refused care the aides would let the nurses know.</p> <p>Review of Resident #6's Behavioral Health note, dated 9/14/24 at 10:42 a.m. revealed the patient was referred to psychological evaluation and possible enrollment of behavioral health services with a history of moderate, major depressive disorder (MDD), adjustment disorder, and dementia. The patient had no history of signs/symptoms (s/s) of psychosis or mania, and no outbursts or behaviors had been reported. The note revealed the resident was dependent on staff for Activities of Daily Living (ADLs). The mental status examination showed the resident had poor insight, judgement, short- and long-term memory, and the fund of knowledge was insufficient and unreliable. The resident had a calm mood, congruent affect but did not respond or give short responses. The note showed the resident was likely not psychologically appropriate due to level of memory impairment related to dementia.</p> <p>Review of the care plan for Resident #6 included the following focuses and related interventions:</p> <ul style="list-style-type: none"> - Has self-care deficits and needs assistance completing activities of daily living (ADLs) due to (d/t) recent cerebral vascular accident (CVA), impaired visual function, stability, poor balance, and mobility. The interventions included instructions for staff to encourage and allow residents to do as much for themselves as safely able and to use of task segmentation in verbal cues as needed (PRN) to promote resident participation in completion of task. - Has a behavior problem as evidence of refusing medications and hitting the CNA with call light. A resident has episodes of yelling and cursing at the staff. Residents has episodes of displaying anger towards staff as evidence of stating get the hell out of here. Resident refused blood sugars. This focus was revised on 5/23/24. The interventions instructed staff to provide opportunity for positive interaction, attention. Stop and talk with him/ her as passing by. In addition to explain all procedures before starting and allowing to adjust to changes, if reasonable discuss behavior explain/ reinforce why behavior is inappropriate and/ or unacceptable. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/23/24 at 1:18 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Health Services Director (RHCD), the NHA reported at approximately 10:00 p.m. on 9/14/24 there was an incident of Resident #6 being combative with care while staff were trying to change her shirt. Staff A had asked Staff B to assist as the resident had refused care and was combative. The NHA reported despite multiple follow-ups (with resident), Staff A and B were assisting to change the resident's shirt and the resident spat at Staff B. The NHA reported Staff B spat back at the resident and held the resident's hands down during the care. Staff B was immediately suspended during the investigation. Staff B reported holding the resident's hands down as the resident was in the mechanical lift. Staff A reported Staff B spit back and the resident and Staff B spit again at each other. The NHA stated unfortunately Staff A did not report the incident right away. The NHA reported Staff B had become aggressive with the NHA, DON, and RHCD during the interview and refused to answer questions. The RHCD reported the allegation (of abuse) was verified as Staff B confirmed holding down the hands of the resident and spitting back at the resident.</p> <p>Review of the policy - Abuse, Neglect, and Exploitation, revised 7/23, showed it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. The definition of willful per policy was the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The compliance guidelines show the facility will develop and implement written policies and procedures that:</p> <p>A. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property;</p> <p>B. established policies and procedures to investigate any such allegations; and</p> <p>C. include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention; and</p> <p>D. established coordination with the QAPI program.</p> <p>The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. Facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:</p> <p>- h. Assigning responsibility for the supervision staff on all shifts for identifying inappropriate staff behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Protection of Resident guidelines reveal the following:</p> <p>The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:</p> <ul style="list-style-type: none"> A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim in resident's; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; F. Emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the residence care plan at the residence medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37999</p> <p>Based on observation, interview, and record review, the facility failed to report an alleged violation involving abuse immediately or no later than 2 hours for one (#6) out of eight sampled allegations of abuse.</p> <p>.</p> <p>Findings included:</p> <p>On 9/23/24 at 10:15 a.m., Resident #6 was observed sitting in a specialized wheelchair in her room. The resident reported mistreatment considering how she was treated and informed writer you're probably the worst one. The resident would not explain the statement related to mistreatment stating, it's over and done with hopefully. The resident reported being blind.</p> <p>Review of Resident #6's Admission Record revealed the resident had diagnoses not limited to unspecified cerebral infarction, unspecified severity unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, recurrent moderate major depressive disorder, and adjustment disorder with other symptoms.</p> <p>Review of Resident #6's progress notes revealed the following:</p> <p>- Late Entry behavior note, dated 9/16/24 at 1:51 p.m. and effective 9/14/24 at 1:49 p.m., Resident sliding out of chair, staff members assisted back up into chair. Resident grabbed staff member by shirt and almost pulled her down. No signs/symptoms (s/s) of distress at this time. Will continue to monitor.</p> <p>- Behavior note, 9/14/24 at 10:14 p.m., Resisting care for transfer to bed and changing clothes and brief. Explained need to have brief changed. Cursing at staff and spitting and resisting care but finally stops resisting and care is completed. Tolerates well and is no longer speaking to staff.</p> <p>An interview was conducted on 9/23/24 at 1:18 p.m. with the Nursing Home Administrator (NHA), Director of Nursing (DON), and the Regional Health Care Director (RHCD). The NHA reported an incident had occurred on 9/14/24 at approximately 10:00 p.m., between Resident #6 and Staff B, Registered Nurse (RN) as witnessed by Staff A, Certified Nursing Assistant (CNA). The resident had refused and was combative with care while staff were trying to change her shirt and at 10:00 p.m. the resident calmed down. The staff had done multiple follow-ups with the resident and as Staff B, RN was assisting, the resident spat at the nurse. Staff A witnessed Staff B spitting back at the resident and held the resident's hands down during the care. The NHA reported Staff B admitted to holding the resident's hands down and spitting at the resident. The NHA reported, during an interview with Staff B she became aggressive towards the interviewers (NHA, DON, and RHCD) and refused to answer any questions. The NHA reported unfortunately Staff A did not report the incident until 1:29 p.m. on 9/16/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview was conducted with Staff A on 9/24/24 at 12:29 p.m. Staff A reported she needed help with Resident #6 as the resident was a mechanical lift and was in the process of getting changed. Staff A reported witnessing the resident spit at Staff B and then witnessed Staff B spit at the resident might have been 2-3 times. Staff A stated after the incident everyone was calm, the resident allowed to be changed. Staff A said (the resident) was probably shocked too. Staff A reported witnessing Staff B hold the resident's wrists down and thought the resident was trying to hit earlier in the night but not at that time. Staff A reported to Staff D, Nursing Supervisor, that Staff B had spit at the resident, and the supervisor told Staff A to write a statement for the administrator. Staff A stated the statement was written on Monday (2 days after the event).</p> <p>Review of an email from Staff A to the NHA on 9/16/24 at 2:03 p.m. an incident had occurred on 9/14/24 at 10:00 p.m. with Resident #6, Staff A, and Staff B. The description showed on 9/14/24 at approximately 8:00 p.m. [Staff A] was attending [Resident #6] who had been refusing care and exhibiting combative behavior. Despite multiple follow-ups, [Resident #6] remained uncooperative. At 10:00 p.m., [Resident #6] had calmed somewhat, and [Staff B] offered to assist with changing [the resident's] shirt. During the process, [Resident #6] spat at [Staff B]. In response, [Staff B] while standing over[the resident] spat back at her. This exchange occurred again when [the resident] spat at [Staff B] who repeated the action. At this point,[Resident #6] was no longer combative, and I did not require further assistance. [Staff B] was excused from the room. The actions taken showed the Staff B was excused from the room to de-escalate the situation.</p> <p>Review of the statement dated 9/16/24, from Staff B, provided by the NHA on 9/24/24 at 1:32 p.m. showed Staff B had reported assisting Staff A with putting Resident #6 into bed at approximately 10:00 p.m. - 11:00 p.m. (on 9/14/24). The resident was resistive to care, hitting, clawing and spitting at staff. Staff B reported holding the resident's hands so the CNA could put gown on. Staff B confirmed Resident #6 spat at her and she may have spit back during aggressive speaking and made spitting noises. The nurse reported Resident #6 was an angry bitter person. The NHA stated the statement from Staff B was done over the phone and was written verbatim with the NHA, DON, and RHCD.</p> <p>A telephone interview was conducted on 9/24/24 at 2:17 p.m. with Staff D, Licensed Practical Nurse (LPN). The staff member confirmed working on the 11 p.m. - 7 a.m. shift, having the most seniority on shift so guessed that made her the Charge Nurse. Staff D reported walking up on the CNA, who had witnessed the incident on 9/14/24, speaking with someone else (unidentified) about the nurse spitting on the resident. Staff D reported advising the CNA if something had happened it would have to be reported. Staff D reported not saying anything to anyone else (regarding the incident) because she was not the supervisor on duty when it happened.</p> <p>During an interview on 11/12/24 at 12:04 p.m. with the NHA, DON, and RHCD, the management team reported Staff A had not reported the incident for 2 days. The DON stated the staff member should have reported to the weekend supervisor who was in the facility until 11:00 p.m. and the supervisor would have notified the DON. The DON stated if another staff member was aware of the situation they should have reported it also. The DON stated she was unaware of any other staff member being aware of the incident. The NHA stated Staff A had texted him on 9/16/24 at approximately 1:00 p.m., prior to the email. The NHA and DON stated they did not interview any other staff regarding the incident. The RHCD stated Staff A was afraid of retaliation from Staff B due to issues in the past, not related to residents and Staff A did not report informing anyone else of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the timeline provided by the NHA related to an incident involving Resident #6 revealed on 9/14/24 at 10:00 p.m. Staff A, was attending the resident who had been refused care and exhibited combative behaviors. The report showed at 10:10 p.m. Staff B had been asked to assist the staff member in changing the resident's shirt and at 10:15 p.m. Resident #6 spat at Staff B who reciprocated the action back to the resident. The report showed on 9/14/24 at 10:25 p.m., Staff B held the resident's hands down and spit back at the resident a couple of times while trying to provide care then was excused from the situation at 10:30 p.m. The report showed on 9/16/24 at 1:42 p.m. (39 hours and 12 minutes after the incident) Staff A called the Nursing Home Administrator to report the incident between Resident #6 and Staff B. On 9/16/24 at 2:52 p.m., Resident #6's physician and family representative were informed of the incident and at 2:55 p.m., 40 hours after the incident, the facility reported the incident to the state agency and law enforcement.</p> <p>Review of the facility policy - Abuse, Neglect, and Exploitation, revised on 7/23, revealed it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse a certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of our residents, irrespective of any mental or physical condition, caused physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including the abuse facilitated or enabled through the use of technology. The definition of willful is described as the individual must have acted deliberately, not that the individual must have been intended to inflict injury or harm. Physical abuse includes, but is not limited to hitting, slapping, punching, fighting, and kicking. It also includes controlling behavior through corporal punishment. Alleged violation is defined as a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.</p> <p>The Reporting/Response component of the policy showed:</p> <p>A. The facility we'll have written procedures that includes:</p> <p>1. reporting all alleged violations to the administrator, state agency, adult Protective Services, into all other required agencies (e.g. Law enforcement when applicable) within specified time frames:</p> <p>a. Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or</p> <p>b. Not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>2. Assuring that reporters are free from retaliation or reprisal;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the state survey agency if the employee believes the facility has retaliated against him/ her for reporting a suspected crime and how to file such a complaint.</p> <p>4. Reporting to the state nurse aid registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service;</p> <p>5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to the following:</p> <ul style="list-style-type: none"> a. analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; b. defining healthcare provision will be changed and/ or improved to protect residents receiving services; c. training of staff on changes made and demonstration of staff competency after training is implemented; d. identification of staff responsibility for implementation of corrective action; e. the expected date for implementation; and f. identification of staff responsible for monitoring the implementation of the plan. 		